Health Reform Implementation Council Public Meeting
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Medicaid Reform

Written Testimony provided by:
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Dear Members of the Health Reform Implementation Council:

As local planners and governmental funders of community behavioral health systems, local mental health authorities provide a unique perspective on the implications of expanding Medicaid programs and changing the behavioral health infrastructure to integrate with primary care. Because all health care is local, the State of Illinois must work with local governmental entities and community based organizations to craft a set of local solutions that address the needs of individuals with mental health and substance use disorders. Our planning for this expansion must include activities and services that go beyond traditional interventions. Coordination, communication, and linkage with primary care can no longer be optional given the prevalence of co-morbid conditions.

The Association of Community Mental Health Authorities of Illinois (ACMHAI) represents mental health boards that plan, fund and coordinate services for people with mental illness, substance use disorders, and developmental disabilities. Local mental health authorities fund over $60,000,000 in services to thousands of individuals in our communities through property tax levies. In our role as governmental payers that represent the communities we serve, we offer the following recommendations to respond to the significant expansion of Medicaid and areas for improvement to ensure Illinois' successful implementation of health care reform:

1. Implications of significant expansion of Medicaid program and changes for improvement

The main issues to resolve with expansion of Medicaid in the behavioral health sector concern funding and workforce. The significant expansion of the Medicaid program will require more physicians, especially psychiatrists, who have been chronically underrepresented within the physicians' workforce as s a specialty provider and state government has not, until recently, provided reimbursement for Nurse Practitioners in Psychiatry. Using a modest estimate of a 15% mental health need and a case load of 300 – 400 per practitioner would necessitate recruiting 7-10 new psychiatrists across the state. Assuming 6% immediate service access of the Seriously and Persistently Mentally Ill (SPMI) population at an average cost of $10,000 per year, this would equate to $63 million. There will also be an increasing movement beyond traditional providers to train family/peer workers and paraprofessionals. These new care managers must be well trained and appropriately paid.

The budget crisis is a huge barrier in Illinois and it will require years to recover from the financial devastation of the mental health system as well as other components of the human services infrastructure. The Division of Mental Health's move to implement benefit limits and higher utilization

criteria makes the expansion unsustainable in the State's current fiscal condition and cost shifts the burden of non-Medicaid eligible clients to local governmental payers.

Payment reform and funding options that would help us through this recovery and make the necessary paradigm shift are:

1) Apply for the Health Homes and Chronic Care Management planning grant;
2) Move toward comprehensive case management and capitated systems;
3) Consider applying for 1115 and 1915 (i) Waiver demonstration programs in communities with mental health boards to implement health home pilots and to provide enhanced community support services to Medicaid beneficiaries who do not meet the institutional level of care criteria, respectively;
4) Use payment incentives to reward quality and outcomes rather than volume;
5) Move from behavioral health carve-outs to integrated care across all systems (acknowledging that an integrated care pilot will soon be implemented in the Chicago area).

In addition to the funding and sustainable practice changes listed above, if health services are integrated, the funding among federal, state, and county government also has to be intertwined. Blended or braided funding forces the elimination of silos with their duplicative eligibility and other tedious administrative requirements by supporting a streamlined comprehensive service system for individuals with complex health issues and their families. Changes in practice and payment to align quality and cost and to achieve desired client and system outcomes will greatly increase the likelihood for sustainability of the newly reformed system.

There are many improvements that can be made to the Illinois health care system with the advent of Medicaid expansion. Because the genesis of these improvements stems from widely accepted principles established at the federal level in preparation for health care reform, we are merely paraphrasing John O'Brien's recent brief, "A Description of a modern addictions and mental health service system". Below is a synopsis of system elements and core structures of the principles from the SAMHSA document that ACMHAI supports for the State of Illinois:

- *Continuum of Services* - Treatment and recovery support services available both on a stand-alone and integrated basis with primary care. SAMHSA's proposed continuum is comprised of nine domains, including: Health Homes; Prevention and Wellness Services; Engagement Services; Outpatient and Medication Assisted Treatment; Community Supports and Recovery Services; Intensive Support Services; Other Living Supports; Out of Home Residential Services; Acute Intensive Services.
- *Community Integration* – Ensures that individuals with behavioral health problems, disabilities and other chronic conditions have supports and services they need to live in a community setting. An array of services would be designed to help people with their housing, school, work, and relationships. The bottom line is that communities work better for people and public payers fund services that promote people staying in their communities.
- *Health Promotion* - Plays a key role in substance abuse and mental illness prevention; provides the opportunity for public payers to support efforts in community and schools with the possibility of engaging the private sector as partners (e.g., employers and insurers).
- *Prevention* - Just as applicable to people at risk for cancer, diabetes, and heart disease, prevention strategies can target those at risk for mental illness and substance abuse. The three levels – universal for the population at large, selective for people at higher risk, and indicated for those with early symptoms or behaviors not yet diagnosed support better health outcomes and

increased productivity. The interrelated impact of mental health and substance use on overall well-being must be acknowledged.

- *Screening and Early Intervention* – Appropriate screenings for mental illness and substance use should be standard and available without cost. At a minimum, depression screening, Screening, Brief Intervention and Referral to Treatment (SBIRT), and screenings available for children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program should be routinely available.
- *Care Management* - Effective care management integrates primary care and specialty health services, including behavioral health. Different approaches must be considered in navigating through the systems, e.g., intensive case management, community support.
- *Self Help and Mutual Support* – Social network support for individuals and families that support recovery will continue to be necessary in the expanded system.
- *Workforce development* – This was previously mentioned as a major concern in Illinois.
- *Empowered Health Care Consumers* - Health care consumers and their families will need information and tools through a system that supports health literacy, shared decision making, and self-directed care. Examples of this are the personal health record and Trilogy's network of care.
- *Information Technology* – Integrated electronic health records, community-wide indicators of mental health and substance use disorders, and outcomes must be collected, stored and shared with the individual and all of his/her providers.

The specific activities for each of these system elements/core structures and how they are implemented are where states and counties vary based on their funding realities, demographics, service providers and community needs. This is an area in which local mental health authorities are crucial resources for identifying the best interventions and strategies to accomplish policy goals and treatment outcomes. Local mental health authorities could also be integral in the collection, storing and reporting of group level utilization and outcomes data to further improve the system. Many of our members are already collecting data to analyze the effectiveness of their funded programs in order to improve outcomes and to discern whether they should continue funding a particular program or pursue a different initiative for a better result.

2. Ensuring continuity of health care – in benefit coverage and in provider networks

Continuity of care should be clear through consistent benefit packages between Medicaid and private health insurance, especially with regard to pharmaceuticals. Parity law ensures that MH/SUD benefits are provided at the same level as other health benefits. Provider networks should include a wide range of providers including community mental health centers, federally qualified health clinics (FQHCs) as well as private physician groups/hospitals. As local government payers, we would like to see that all payers are able to share service information and leverage resources to better serve our DD, MH, and SUD clients. One central database that combines all public funders' revenue and expense data by clients to be able to track services, costs, and outcomes would truly enable us to cost analyze care. We need to do a better job of inventorying services, analyzing costs, utilization, and outcomes across all the systems of care.

3. Incorporating the integration of medical services into Medicaid

The State should incorporate integration of medical services through health home models that have been piloted in other states and in Illinois, including: Bright Futures (for children); collocation of behavioral health and primary care services; FQHCs assuming responsibility for psychiatric care for individuals with mild to moderate behavioral health problems; and specialty mental health/substance use treatment agencies caring for individuals with severe mental illness and/or substance use disorders, with advanced practice nurses or physician assistants on staff.

Special treatment providers and the mainstream health care delivery system will have to coordinate care, especially for children and youth, who often require linkages with education, child welfare or juvenile justice systems. Expansion of services for children through EPSDT will greatly enhance integration of care and coordination across systems as parental knowledge of behavioral health rehabilitation services and access to those services increase.

4. Changes to long term care services system

The State must first address the inadequacy of community based options, including affordable housing, to improve the quality of care and movement from institutional care to community care. The community has proven the ability to provide quality care and reduce institutional stays, but lacks the resources to sustain and maintain the care. The waiting list for Developmental Disability placements and movement from nursing homes for those with mental illness are critical issues that need to be resolved. As part of the development of a waiver and/or revision to the state Medicaid plan, the State should explore with CMS how best to revise the IMD exclusion, and redirect funding from institutional care (currently 80% of total funding for long-term care in Illinois) to community-based care. The 1915 (b), (c), or (i) waivers also serve as tools to meet obligations under ADA and Olmstead.

For the small percentage of adults with serious mental illness and children with serious emotional disturbances who consume a majority of resources, our system would benefit from developing special needs plans, health homes and accountable care organizations. Specifically for children who need long term residential services we support expanding medically necessary residential options (Psychiatric Residential Treatment Facilities) as a part of a continuum of community-based services, thereby eliminating the need for custody relinquishment in order to access mental health treatment. A demonstration pilot could be requested through a 1915 (b) waiver or consideration could be given to expand the scope of the current PRTFs in Illinois that serve children with substance use disorders.

Conclusion

First and foremost, ACMHAI, representing local governmental planners and funders of mental health, substance use disorder, and developmental disabilities services, offers to serve as a resource to the Health Reform Implementation Council as you prepare for specific activities that will lead our state to successful implementation of health reform. We are the experts in our own communities on how we need to improve the health care system, both in terms of the infrastructure and the needs of individuals, families, and community-based providers who serve them. Please help us reduce the stigma that still exists regarding mental illness and substance use disorders by promoting policies that attend to these health conditions with equal importance to any other chronic illness. We know there are still significant boundary issues among the mental health, addiction, primary care and other social service systems. ACMHAI pledges to continue to work on creating partnerships with primary care, public health, schools, criminal justice, and within the behavioral health/disabilities system.